UNITED STATES TRANSPORTATION COMMAND
Scott Air Force Base, Illinois 62225-5357

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Aeromedical Evacuation

A QUICK REFERENCE GUIDE FOR REPORTING PATIENTS AND ATTENDANTS FOR MOVEMENT

This pamphlet is a synopsis of the guidance provided in various regulations and operating policy. The primary sources of authority are: Department of Defense (DOD) Instruction 6000.11, Medical Regulating; and Air Force Policy Directive (AFPD) 41-3, Worldwide Aeromedical Evacuation.

The provisions of the Privacy Act of 1974 should be strictly adhered to. Attachment 2 to this pamphlet is an example only and may require a disclosure statement under the provisions of the Privacy Act.

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Commander, 375th Aeromedical Evacuation Squadron (375 AES).....DSN 576-3070
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All Scott AFB extensions may be reached by dialing 1-800-851-7542 and ask for the extension. (FOR OFFICIAL BUSINESS ONLY)

1. ELIGIBILITY FOR PATIENT MOVEMENT.

1.1. The following categories of personnel are authorized patient movement:

1.1.1. Active duty military and US Coast Guard and their dependents.

1.1.2. Retired military and US Coast Guard and their dependents.

1.1.3. Beneficiaries of the US Public Health Service (USPHS) which include:

1.1.3.1. Commissioned officers of the USPHS and the National Oceanic and Atmospheric Administration.

1.1.3.2. Civilian seamen in the service of ships operated by the Military Sealift Command (MSC).

1.1.3.3. Certain beneficiaries of the USPHS Division of Indian Health, provided USPHS has issued prior authorization for their movement.

1.1.4. Department of Veterans Affairs (VA) beneficiaries. These beneficiaries are moved either under title 10, United States Code, Section 2641 on a space-available basis, or under the Economy Act on a fully reimbursable basis regardless of DOD patient requirements, assuming the mission is already required to stop at that location for a DOD patient. One copy of orders or appropriate authorization, including fund citation or billing information, will be sent to Global Patient Movement Requirements Center (GPMRC), ATTN: Financial Assistance, Scott AFB IL 62225-5049 or submitted to the crew at the time the patient boards.

1.2. Under title 10, United States Code, Section 2641, the VA incurs charges for patients and nonmedical attendants who remain overnight within an Aeromedical Staging Squadron or other intermediate medical facility and a per mission inflight medical charge.

[CI] **1.3.** Under title 10, United States Code, *Section 2641a*, there is a limited authority to transport American Samoa veterans on DOD aircraft for medical care in Hawaii. Such transportation is only between Samoa and the State of Hawaii; must be approved by the VA; and is only provided on a space-available basis.

2. PATIENT MOVEMENT OF PERSONS NOT NORMALLY ELIGIBLE.

2.1. Guidance for movement of persons who are not normally eligible is contained in DOD Instruction (DODI) 6000.11, Medical Regulating. Such cases are handled on an individual basis. Requests for movement must be approved by the GPMRC Patient Movement Operations Officer (PMOO) prior to reporting a complete patient record.

2.2. Provided below is a synopsis of situations that may be considered for movement:

2.2.1. There must be an immediate threat to the patient's life, limb, or eyesight. Moves of this nature are normally limited to those that are lifesaving.

2.2.2. Required medical capability is not in the immediate geographic area.

2.2.3. Commercial transportation is not available or suitable (air ambulance, air taxi, scheduled air carrier, or surface carrier). Absent a medical need for immediate movement, only air carriers approved by DOD, pursuant to the release of DOD Directive 4500.53, will be used for the transport of DOD patients. Lack of funds to pay for commercial transportation is not a consideration.

2.3. Cases generally not acceptable for movement:

2.3.1. Provide financial relief for the patient or patient's family.

2.3.2. Personal or family convenience.

2.3.3. Medical experimentation (unless determined by competent medical authority that such experimentation will save a life).

2.4. Requests must contain:

2.4.1. Name, age, and sex of patient.

2.4.2. Affiliation of patient (employee of private firm, DOD, Federal Government, etc.).
2.4.3. Complete medical diagnosis and prognosis.
2.4.4. Name and phone number of attending physician.
2.4.5. Name and location of originating hospital.
2.4.6. Name and location of destination hospital.
2.4.7. Name and phone number of receiving physician.
2.4.8. A statement that use of commercial transportation facilities has been fully explored and cannot meet the requirement.
2.4.9. Name and phone number of person requesting transportation.
2.4.10. Billing address (lifesaving missions will not be delayed pending receipt of billing address).
2.4.11. Name and phone number of persons responsible for surface ambulance transportation at both origin and destination.
2.5. One copy of orders or appropriate authorization, including a fund citation or billing information, must be sent to GPMRC, ATTN: Financial Assistance, Scott AFB IL 62225-5049.

3. PATIENT CLASSIFICATIONS AND CONSIDERATIONS (Reference Air Force Instruction 41-301).
3.1. NEUROPSYCHIATRIC CATEGORY
3.1.1. 1A - Severe psychiatric litter patients. Psychiatric patients requiring the use of restraining apparatus, sedation, and close supervision at all times.
3.1.2. 1B - Psychiatric litter patients of intermediate severity. Patients requiring tranquilizing medication or sedation, not normally requiring the use of restraining apparatus; however, restraining apparatus must be provided for potential use.
3.1.3. 1C - Psychiatric walking patients. Cooperative and reliable under observation.
3.2. INPATIENT LITTER CATEGORY
3.2.1. 2A - Immobile litter patients, nonpsychiatric, who are not able to move about on their own volition under any circumstances.
3.2.2. 2B - Mobile litter patients, nonpsychiatric, who are able to move about on their own volition under emergency circumstances.
3.3. INPATIENT AMBULATORY CATEGORY
3.3.1. 3A - Ambulatory patients, nonpsychiatric and nonsubstance abuse, going for treatment or evaluation.
3.3.2. 3B - Recovered patients, returning to home station.
3.3.3. 3C - Ambulatory, drug or alcohol (substance) abuse going for treatment.
3.4. INFANT CATEGORY
3.4.1. 4A - Infant, under 3 years of age, occupying a seat.
3.4.2. 4B - Recovered infant, under 3 years of age, occupying a seat.
3.4.3. 4C - Infant requiring an incubator.
3.4.4. 4D - Infant under 3 years of age occupying a litter.
3.4.5. 4E - Outpatient under 3 years of age.
3.5. OUTPATIENT CATEGORY
3.5.1. 5A - Outpatient ambulatory patient, nonpsychiatric and nonsubstance abuse, going for treatment.
3.5.2. 5B - Outpatient ambulatory, drug and alcohol (substance) abuse going for treatment, includes family member going for "Family Week."

3.5.3. 5C - Psychiatric outpatients, going for treatment or evaluation.
3.5.4. 5D - *Outpatient on litter for comfort.
3.5.5. 5E - *Returning outpatient on litter for comfort.
3.5.6. 5F - Returning outpatients.
* A seat will be provided for patient, if available.
3.6. NONPATIENT CATEGORY
3.6.1. 6A - Medical Attendant. Medical attendants supervise and assist in the inflight care of the patient. They must be familiar with the patient and their care. Providing needed attendants is the responsibility of the originating facility, and the attendant *must* accompany the patient to the destination facility unless alternate arrangements have been coordinated by GPMRC prior to launch. Medical attendants may be physicians, nurses, respiratory technicians, or medical technicians depending on the patient's clinical status and care needs. Patients to be transported on a cardiac monitor require a physician attendant or specially trained nurse in accordance with Air Force Instruction (AFI) 41-301. Patients on mechanical ventilation require a respiratory therapist and/or a physician to accompany them. For questions or further information contact the Patient Movement Clinical Coordinator (PMCC) at GPMRC (DSN 779-8157).
3.6.2. 6B - Nonmedical Attendants. One adult, normally a family member, may accompany a patient as a nonmedical attendant (NMA) if deemed necessary by the attending physician. Guards that accompany patients in correctional custody are reported as NMAs. Attendants should be advised to have sufficient money to pay for food and accommodations. *All* attendants *must* accompany the patient to the final destination. Waivers may be granted by the PMOO at GPMRC for unusual circumstances. Attendants must be self-care and ambulatory; e.g., a sole NMA should not be a small child or aged invalid. Physician recommendation for NMA should be included on patient's medical record and Department of Defense (DD) Form 602, Patient Evacuation Tag/AF Form 3899, Aeromedical Evacuation Patient Record.

4. CLOTHING. Ambulatory patients and attendants may be in appropriate civilian clothing. Litter patients should be in hospital attire; however, recovered litter patients often return ambulatory. Therefore, ensure they pack appropriate clothing. From 1 October through 30 April, ensure your litter patients have two blankets. Ambulatory patients may have to transit cold climate bases. Ensure they are properly clothed. Do *not* send patients or attendants into winter weather dressed in summer attire.

5. PSYCHIATRIC PATIENTS. Close attention should be rendered to patients with a neuropsychiatric classification. They will not be allowed items that present a danger to themselves or others; however, common sense should be the guiding factor in determining what is or is not dangerous. These patients may possess some valuables; e.g., wedding band, watch, religious medal, etc., and cash - not to exceed $25. Other valuables and money exceeding $25 should be sent registered mail to the destination hospital. They may not possess sharp objects, matches, cigarette lighters, etc.

6. TRANSPORTATION OF UNACCOMPANIED MINORS/INCOMPETENT PATIENTS.
6.1. A DD Form 2239, Consent for Medical Care and Transportation in the Aeromedical Evacuation System, must accompany the following patients:

6.1.1. Unaccompanied minors under 18 years of age. Specifically, minors under 14 must have an attendant. If a parent or guardian cannot accompany the minor under 14, the originating medical facility must supply a responsible adult as a non-medical attendant (NMA), a DD Form 2239, and a Power of Attorney (POA) identifying the NMA as the responsible agent for the mission. Minors over age 14 may travel alone but must have DD Form 2239 attached to the DD Form 602/AF Form 3899. If the parent or guardian is unavailable to sign DD Form 2239 or the POA and obtaining either by e-mail or facsimile is not possible, the originating hospital may accept a telephone consent with two witnesses who verify the call and sign DD Form 2239 or the POA. Emancipated minors (e.g., married to a military member) do not require this form.

6.1.2. Minors accompanying a parent/guardian when the parent/guardian is a *patient category*.

6.1.3. *Unaccompanied non-active duty adult patients* who are not capable of directing their own care (i.e., comatose patients, confused/disoriented patients, etc.).

6.1.4. *Accompanied non-active duty adult patients* who are not capable of directing their own care and who are not accompanied by their legal guardian (determined by the military treatment facility (MTF)), DD Form 2239 will authorize AE system to direct medical care of patient while in system.

6.2. The DD Form 2239 will be filed in the patient's medical record with a copy attached to the DD Form 602/AF Form 3899 and will be annotated with the parent/guardian's address and telephone numbers. If the authority for the legal guardian of an adult patient not capable of directing their own care is a health POA, a copy of the POA should be included in the patient's medical record. The above situations are only a guide to when a DD Form 2239 is required. Some situations are more complex and the need for a DD Form 2239 will be decided by the PMCC at the time of reporting or ultimately by the Medical Crew Director at the flightline. Every effort should be made to accomplish this *prior* to flight. In the above situations where a POA is not required, use/requirement of a POA should be considered and may be desirable, in the event it does not delay patient movement. Any questions or further need for guidance in this area should be directed to the PMOO or PMCC at GPMRC, DSN 779-8157 or commercial (618) 229-8157/1-800-874-8966.

7. EQUIPMENT.

7.1. The following equipment is routinely carried on board all routine AE missions:

7.1.1. Bassinets which are available for infants.

7.1.2. Car seat for children weighing 7-40 lbs. Parents may bring their own Federal Aviation Administration (FAA)-approved car seat. An FAA sticker must be on the car seat or it will not be used.

7.1.3. Incubator for infants.

7.1.4. Life Support. Positions for oxygen, suction, and electrical equipment are located throughout the aircraft cabin.

7.1.5. Cardiac Drugs. Medical equipment normally carried aboard all aircraft include emergency cardiac arrest supplies and the adult and pediatric ambu bags (in accordance with Advance Cardiac Life Support (ACLS) standards).

7.1.6. Cardiac Monitor. Battery or AC-powered unit. If used to monitor heart rate, a physician or specially trained nurse must accompany patient. If used for infant to monitor apnea, a physician may be required if the infant is unstable. This is determined by the Theater validating surgeon. This unit can be used for defibrillation of adults, children or infants.

7.1.7. Intravenous Infusion Pump. The Medical Technology Products (MTP) model 1001AF and the Allaris Med System III intravenous (IV) infusion pumps are approved for use on the aircraft.

The Allaris Med System III may also be used to control continuous enteral feedings. Other types of IV pumps may be used if previously approved for aeromedical evacuation.

7.1.8. Collins (The Collins Traction Device). Swinging weights are unreliable and unsafe in a moving environment. The traction should be applied prior to airlift. This device can maintain up to 60 lbs of traction for midline traction only. This equipment may not be routinely carried on Continental United States (CONUS) C-9 missions, please contact GPMRC for guidance.

7.1.9. Chest Drainage Units. To provide water seal drainage of the pleural cavity and suction control for patients with chest tubes. The Pleur Evac, Thora-Drain, Pleuragard, Thor-Klex and Argyle chest drainage units are all approved for flight. Glass bottles will not be used.

7.1.10. Heimlich Valve. Patients with chest tubes should have a Heimlich valve in place. Chest tubes must *not* be pulled within 24 hours of airlift due to the possibility of pneumothorax. Recent chest x-ray and blood gases should accompany these patients, if available.

7.1.11. Pulse Oximeter. Used to monitor patient's oxygen saturation.

7.2. The following equipment will be placed on board a mission, if requested, when reporting a patient:

7.2.1. Oxygen Analyzer. Used to analyze percentage of oxygen being delivered such as with the ventilator, incubator, etc.

7.2.2. Baby Bird Ventilator. Ventilator for infants and children. A physician must accompany the patient.

7.2.3. Bear 33 Ventilator. A physician or respiratory therapy technician or both, depending on the patient's diagnosis and condition, should accompany a patient requiring this equipment in flight.

7.2.4. Stryker. The Stryker frame. All parts must be sent with the frame as they are not interchangeable. The 6- or 7-foot frame can be used but only 7-foot frame is kept in our inventory. All connections should be secured with the Allen wrench prior to movement to the aircraft. If you do not have a Stryker or do not want to give up your only one, contact us ahead of time and we will preposition one for your patient.

7.2.5. Overweight Litter (OWL). Overweight litter is used for patients weighing in excess of 250 lbs. The OWL may be prepositioned for patients originating from MTFs other than Scott AFB IL.

7.3. Since a mission may remain overnight (RON) at specific locations, equipment may need to be prepositioned. Report patients requiring equipment in a timely manner to allow for adequate mission preparation. (The equipment used on AE missions must be tested and approved by Armstrong Laboratories.) Occasionally, because of time or mission constraints, the GPMRC may ask the medical facility to supply equipment. When this occurs, the equipment will be returned normally on the next AE mission servicing the medical facility.

7.4. The originating MTF must use only flight-certified equipment for patient care during any AE mission. Questions concerning non-certified equipment should be directed to GPMRC or the appropriate Theater Patient Movement Requirements Center (TPMRC); be prepared to provide: equipment manufacturer, model number, serial number, equipment description, and power sources. Please contact GPMRC for questions or a complete listing of equipment authorized by Armstrong Laboratories for use in the AE system.

8. PATIENT PREPARATION. Adequate patient preparation starts when the attending physician decides the patient needs treatment in another facility and requests the patient be regulated and transported via the Patient Movement System.

8.1. The following must be completed by the *physician*:

8.1.1. Request for patient movement. For the Air Force (AF), this is an AF Form 230. For all other facilities, check local policy for the correct procedure.
8.1.2. Complete patient report:
8.1.2.1. AF Form 3839, Patient Reporting Data Collection Sheet, with complete medical information (Attachment 2).
8.1.2.2. DD Form 602, Patient Evacuation Tag/AF Form 3899, Aeromedical Evacuation Patient Record. Checked and *signed* by the physician to include special diets, medications with dosages and treatments (i.e., turn every 2 hours). The physician's name stamp should be placed under the signature block. The DD Form 602/AF Form 3899 becomes a permanent and legal part of the patient's medical record. See paragraph (8.2.7.), DD Form 602, Patient Evacuation Tag.
8.2. The following should be completed or discussed by the AE Clerk or Medevac Clerk:
8.2.1. Completion of the AF Form 3839.
8.2.2. Defense Medical Regulating Information System (DMRIS). Reporting the patient via DRMIS. Report early, 48 hours in advance is preferable. *Patients must be stable prior to reporting* (i.e., not scheduled for surgery prior to move). (See Attachment 5.)
8.2.3. AF Form 3840, Patient Transfer Information and Reaction. The AF Form 3840 must be provided to the patient well in advance of movement. This will give the patient sufficient time to read, understand, and comply with the contents of the guide.
8.2.4. Orders. *All* patients and attendants (medical and nonmedical) must have valid travel orders.
8.2.5. Medical Records. All medical records including laboratory results, x-rays, physician and nursing notes, and narrative summary or consult for outpatients, must be sent to the flightline and delivered to the Medical Crew Director (MCD). Records may be hand carried by the patient if deemed appropriate by the originating facility. Unaccompanied records will not be accepted by the MCD.
8.2.6. Medications. A 5-day supply of medications, tube feedings, and treatment supplies for the patient must be provided in order to ensure continuous care while in transit. Patients returning to or from overseas must have a 7-day supply of medications. Patients may carry and take their own medication provided this is indicated on the front of the DD Form 602 (i.e., self medicating). Patients carrying their own medications must be briefed to keep them in their *hand-carried bag*. Refer to Attachment 8 for a listing of medications routinely carried aboard AE aircraft.
8.2.7. DD Form 602, Patient Evacuation Tag; and AF Form 3899, Aeromedical Evacuation Patient Record. The physician must be specific concerning treatment and medication: type, frequency and dosage. All medications and treatments must be listed even if the patient is self-medicating. In the space provided, the ward nurse will annotate the time and dosage of the last medication. To ensure optimum patient care, include all necessary patient information. Attach a copy of the narrative summary and patient medication record for inpatients, or a copy of the consultation sheet for outpatients, to the DD Form 602/AF Form 3899. The DD Form 602/AF Form 3899 is a legal document and must be signed by the attending physician. It becomes a permanent part of the patient's medical record.
8.2.8. Wired Jaws. Patients with wired jaws must have a quick release mechanism or wire cutters in their possession. Wire cutters must be provided by the originating medical facility.
8.2.9. Infants. It is the responsibility of the originating medical facility to provide all infant care necessities (i.e., bottles, formula, diapers, etc.) and ensure that they are placed on board the aircraft at the time the patients are enplaned (see paragraph 6, Transportation of Unaccompanied Minors).

8.2.10. Add-on Patients. Add-ons must be coordinated with the PMCC. Same day add-ons in most cases, will be accepted for movement provided the facility stop already exists on the mission and the mission has space available, required special equipment is on the aircraft, and sufficient medical information can be obtained to permit an adequate preflight clinical evaluation. Final decision on acceptance is solely at the discretion of GPMRC.

8.2.11. Supplemental Information. Facts contained in this pamphlet, such as access to stowed baggage, that patients may be subject to overnight and en route stops, differences in climate from originating facility to destination facility, and expenses for attendants or outpatients, etc., are all examples of supplemental information for your patients. We recommend AE clerks develop a checklist of these items from which to brief patients and attendants prior to movement. Contact GPMRC for assistance in developing patient briefings.

8.2.12. Neuropsychiatric patients. Attention must be paid to restrictions for these patients as outlined under Patient Classifications and Considerations.

8.2.13. Patient Baggage. The most frequent causes of baggage loss are improper completion of DD Form 600, Patient Baggage Tag, inadequate packaging, and lack of proper identification. The following list of guidelines summarized from aeromedical evacuation regulations will help ensure that the patient's baggage arrives with the patient:

8.2.13.1. Stowed baggage may not have dimensions exceeding 62 inches in any one direction or 100 inches overall (length+width+height) and must be sufficiently durable to withstand handling during transportation. *TV sets and musical instruments will not be accepted.* Sports equipment in durable containers may be accepted.

8.2.13.2. Ensure the DD Form 600 is firmly attached to *all* stowed baggage before it departs your facility. Print all entries completely and clearly. The patient should be given the stub from the tag as a receipt. If the patient is unable to safeguard the stub, it should be attached to the patient's medical records. Medical treatment facilities should change the DD Form 600 for patients returning to their home station. The baggage tags should not be the same ones they had going on the first trip. This is probably one of the quickest ways for patients to become separated from their baggage.

8.2.13.3. Normal baggage allowance is 2 pieces of stowed baggage not to exceed a total of 66 lbs for each patient or attendant.

8.2.13.4. Hand-carried baggage is restricted in size in order to fit under the aircraft seat. For C-9 aircraft, hand-carried baggage cannot exceed 8 1/2"x12"x20" and for C-141 aircraft 12"x18"x36". Ensure a DD Form 600 is firmly attached to all hand-carried baggage and destroy stubs in compliance with 375 AES policy. Patients should be limited to one hand-carried item as space is limited aboard the aircraft. Print all entries clearly. See Notes 1, 2, and 3.

8.2.13.5. *One copy of travel orders should be placed in each bag* to assist in identification should the item become separated from the patient.

8.2.13.6. Thin, weak, poorly-constructed containers, and all other articles deemed to be unsafe, insecure, potentially damaging to the aircraft or otherwise hazardous will not be accepted.

NOTE 1. Expect *these dimensions to be less on C-9s because part of the underseat area is taken up by the life preserver.*

NOTE 2. Strongly recommend that patients carry a change of clothing and toiletries in their hand-carried bags, since they may not have access to their stowed baggage while en route.

NOTE 3. Put medications in hand-carried baggage, not stowed baggage, for all self-medicating patients.

9. ROUTINE PATIENT REPORTING:

9.1. Routine patients are picked up on routinely scheduled patient movement missions, normally within 3 days of the date they are reported ready to be moved. While patients may reach their destination medical facility the same day they leave their originating facility, it is very common for patients to RON at an Aeromedical Staging Squadron (ASTS). Mission requirements or routing can result in patients remaining in the Patient Movement System for up to 5 days. *Patients should be briefed on this possibility by the originating medical facility.*

9.2. Report routine patients directly to GPMRC. It is essential that a complete report be provided to GPMRC in order for the Patient Movement System to continue to provide a level of health care delivery that is consistent with the needs of the patient. Specifically, any special information mentioned in the Patient Reporting Guide (Attachment 3) and the specialty of any medical attendant, i.e., nurse, med tech, or physician should be noted. GPMRC is responsible for ensuring *inpatients* are regulated to appropriate medical treatment facilities, usually the MTF with specialty capability closest to the transferring MTF. At this time, GPMRC does not regulate *outpatients* but accepts reports for outpatients being moved via the Patient Movement System.

9.3. All patient reports are reviewed by PMCC and medical regulators based on diagnosis, classification, age, and other factors. Patients will not be considered for movement unless complete information is provided to GPMRC. Additional clinical information must be obtained for many patients. This necessary quality assurance step is both time-consuming and time-constrained and can only be effectively accomplished during normal duty hours when providers with knowledge of the patient's clinical status are available. The PMCCs are on duty from 0800-1800 central time and a regulator will be on duty 0600-1800 central time to make these follow-up calls. In an emergency, a PMCC can be contacted at any time by calling GPMRC at 1-800-874-8966. When you check your Defense Medical Regulating Information System (DMRIS) Name-SSAN Cross Reference Screen for the patient's cite number and see any of the following messages: "ERROR, Call GPMRC, Call PMCC, Canceled, Not Moved", you need to call GPMRC, DSN 779-7150/8157 (direct lines). Have all available information about the patient in front of you, so that you can give the additional clinical information required in a timely and complete manner, precluding the need for additional telephone calls. If you check DMRIS and the message "PMCC Pending" appears, then the record is still under review. Wait at least 1-2 hours then check the screen again. If after 2 hours the record has not been validated, then call GPMRC. You should call for guidance anytime you are unsure of an error message.

9.4. Patients in civilian or Veterans Administration (VA) facilities are reported in the same manner as other patients; the only exception is a civilian facility package (Attachment 4) must be completed and faxed to GPMRC at DSN 779-0116/0118 or commercial (618) 229-0116/0118 prior to the patient being regulated. See Attachments 2, 5, 6 and 7 for specific forms completion requirements.

9.5. All active duty patients going to a VA facility must have a VA bed request put into the system prior to a record being entered.

9.6. At 1800 (central time) Mon - Thu, the following day's mission itinerary is set; at 1800 (central time) on Fri, the mission itineraries for Sat, Sun, and Mon are set. These itineraries will not normally be changed for routine precedence patients. If patients are enplaning at an existing stop on the mission and the mission has space available, then the patient may be added to the mission at the discretion of GPMRC. Only those routine precedence patients reported in advance of established cutoff times will be considered for movement under the Patient Reservation System

(PRS). *Reports must be received in time for PMCCs to obtain sufficient medical information and permit adequate clinical preflight evaluation, thus assuring quality patient movement.*

9.7. Report a patient immediately upon knowledge of the movement requirement and if the patient is stable. Cite numbers are good for 7 days after issue. Routine patients may be reported any time from 0600 to 1800 (central time) on normal duty days.

9.8. Under the PRS planning cycle, GPMRC can manifest patients on missions several days in advance. Patient concerns and uncertainties about their flight can be minimized and the MTF planning for incoming and outgoing patients can be enhanced. The patient movement schedule in CONUS will fly as published as long as patient requirements exist at a scheduled stop. The schedule may be changed on occasion to respond to certain special requests, priority and urgent patients, mechanical problems, weather, etc. During the Thanksgiving, Christmas, New Year, Memorial Day, Independence Day, and Labor Day holidays, the schedule will reflect days when no routine missions will be flown. It is our intent to minimize these fluctuations as much as possible.

9.9. In the event your system goes down and you are not able to enter patient movement requests, the following steps must be followed:

9.9.1. Notify your facility systems manager.

9.9.2. If your systems manager cannot correct the problem, then they must call the Electronic Data System (EDS) Help Line at 1-800-538-9500 or 703-578-5000.

9.9.3. If EDS cannot correct the problem, then ask them for a ticket number.

9.9.4. After you receive your ticket number, call GPMRC and tell them your system is down, you have a ticket number, and you need to fax your records for patients that are flying the *next day*. The records can be faxed to DSN 779-0116/0118 or commercial 618-229-0116/0118.

9.10. Procedures for patient reporting for non-DMRIS facilities..

9.10.1. The following procedures are to be used when reporting patients for input into the DMRIS system by facilities which do not have DMRIS capability.

9.10.1.1. AF Form 3839, Patient Reporting Data Collection Sheet, must be completed (Attachment 2). This form may be handwritten, but must be legible. Include items on the reverse of the form.

9.10.1.2. After completing AF Form 3839, call GPMRC at DSN 779-7150/8157 or commercial (618) 229-7150/8157 and let the regulators know you are faxing records to be entered into the system and the number of records.

9.10.1.3. You should call GPMRC after the fax is transmitted to ensure all pages have been received and are legible.

9.10.1.4. Before you leave at the end of the day, call for cite numbers and correct any errors. *Records should be submitted at least three working days prior to the scheduled flight to allow ample time for errors to be corrected. Exceptions will be considered on a case-by-case basis.*

9.10.2. When completing the AF Form 3839, all blocks should be completed including any lab work, especially important for chemotherapy patients, inpatients, and patients with blood disorders. If lab results are not available, then a statement to that effect should be made in block 47. Vital signs should also be entered.

9.10.3. All diagnoses must be coded and a brief statement made in the history; i.e., patient has hypertension controlled by meds. Also all medications must be listed in block 64. For patients with more than three diagnoses, code the three primary reasons for patient movement in blocks 28-32, then put a brief statement in the history about any others.

10. PRIORITY AND URGENT PATIENT REPORTS.

10.1. Priority precedence applies to the need for prompt medical care not available locally. Urgent precedence applies only to the need for immediate life, limb, or eyesight saving procedures. To report urgent and priority patients, have the attending physician contact the PMCC directly at DSN 779-7139/7155. It is important that the AE Clerk alert GPMRC as soon as possible to begin the processing of the urgent or priority movement request. This will allow GPMRC time to look at all options in order to provide optimum support. Do not wait for all the lab and X-ray results to return before alerting GPMRC. The AE Clerk may always call back later to cancel or confirm the move. When reporting these patients, contact the PMCC on duty at DSN 779-7155 or 1-800-874-8966. The PMCC will require all of the standard patient information detailed under *patient reporting* (para 9.10). Both priority and urgent patients are moved on a doctor-to-doctor referral basis due to the specialized care that the patient will require. This means that the attending physician *must* contact a specific physician at the destination hospital. The accepting physician or staff personnel must confirm acceptance by telephoning GPMRC. It is the attending physician's responsibility to ensure that the receiving physician calls GPMRC. Additionally, the attending physician must be available to discuss the patient with the PMCC and occasionally with the Theater validating surgeon. An AF Form 3839 will be prepared by the PMCC on every priority and urgent patient entered into DMRIS. You can get an idea of what questions you will be asked if you look over the form before reporting such patients (Attachment 2). The PMCC may request you fax a copy of a completed AF Form 3839 or that you enter the patient's AF Form 3839 into DMRIS.

10.2. Terminally ill and psychiatric patients are not normally accepted for movement on an urgent or priority basis.

10.3. Report all burn patients directly to the Brooke Army Medical Center, Ft Sam Houston TX at DSN 429-5501/0501/2876/2604/0943 or commercial 1-210-222-2876.

11. ESTIMATED TIME OF ARRIVAL (ETA). The GPMRC night shift places telephone calls to military treatment facilities that will receive a patient movement mission the following day. The GPMRC staff will make notifications early. All civilian facilities and the VA Hospitals will receive telephone calls. These telephone calls are to coordinate mission information and are placed to the office designated by the facility as a 24-hour operating office. This information needs to be written down and we highly recommend the use of the Aeromedical Evacuation Data Worksheet (Attachment 9) or a locally developed form. The information needs to be passed to the AE Clerk in the morning. The use of the data sheet or local form will ensure the proper information is passed and an audit trail is established to correct internal problems. To maintain a prompt mission schedule, arrive at the flightline 15 minutes prior to the estimated time of arrival (ETA) (unless a patient's condition dictates otherwise). Our "Fly the Schedule" policy has vastly reduced our early/late arrivals and is allowing us to keep to our scheduled arrival and departure times. However, there are many factors that influence the ETA which may result in earlier or later arrivals, such as weather conditions, mechanical problems, etc. GPMRC personnel will do their utmost to keep the AE Clerk informed. Should there be questions about a scheduled mission or if incorrect or inadequate information is suspected, call the GPMRC.

12. ANTI-HIJACK INSPECTION. All military medical facilities *must* provide to the Medical Crew Director a search certificate stating that all patients, attendants, and their hand-carried baggage have been searched for firearms or weapons. Perform a thorough search that the people

affected may witness. A transfrisker (metal detection device) is carried on board all missions for patients originating from civilian facilities. Failure to accomplish a valid search could endanger the lives of patients, crews and passengers. No patients, attendants, or their baggage will be enplaned without this inspection. Patients and attendants will be asked if this inspection was performed prior to enplaning (AF Instruction (AFI) 13-207).

13. FLIGHT ARRIVAL. Sufficient personnel *should* be sent from the medical facility to assist the enplaning and deplaning patients. A nurse or medical technician should be available to give report on patients being enplaned. In the event a patient requires complicated traction or is critically ill, a physician or nurse, as indicated, must accompany the patient to the flightline. Exercise extreme caution when moving a vehicle close to the aircraft. Have the drivers follow the instructions of the AE personnel.

14. GROUND TRANSPORTATION. The aeromedical evacuation system provides *air transportation from airfield to airfield only.* GPMRC will notify the originating and receiving facilities, or other designated activities, of the estimated aircraft arrival time and will ensure that ground transportation is arranged. It may generally be assumed that military medical facilities will meet and pickup patients going to their facility for treatment or returning from treatment. However, this is not always true for civilian hospitals. Therefore, the GPMRC will not accept requests for movement to or from civilian hospitals (including VA medical centers) unless prior arrangements for transportation have been made and a point of contact with telephone number is provided.

15. AIRLIFT OF DONOR ORGANS.

15.1. Organ movements are reported as urgent moves in the same manner as patients. The significant differences are that organ donors can qualify as urgent patients when being moved to donate an organ and will be in surgery as soon as possible upon arrival. The methods and types of aircraft used in moving organs alone can be selected with more flexibility. In some cases, the use of available high speed aircraft has been accomplished. It is important to note that the time frame for obtaining viable organs is limited usually to less than 4 hours. Therefore, the practicable range of retrieval of an organ is limited.

15.2. Organ recipients established as acceptable candidates for transplant can be validated in advance for such time that an organ becomes available. Note that if a recipient is seriously ill, it is often more valuable to place the recipient at the facility which will do the transplant, while waiting for an organ to be located and harvested.

16. DO NOT RESUSCITATE POLICY (DNR). In AE, an order for DNR is synonymous with no code *meaning that no emergency resuscitative measure will be done in the event a patient ceases to breathe or loses a pulse.* This definition is important so that the doctor's order for DNR is not confused with other types of orders being used by individual medical facilities. Partial codes (i.e., CPR only, no intubation, chemical code only, etc.) are *not* accepted for AE. Such requests must be discussed and approved on a case-by-case basis with the Theater validating surgeon through GPMRC.

16.1. Aeromedical Evacuation Crew Members (AECM) will comply with DNR orders, subject to the following requirements (IAW AFI 41-301):

16.1.1. The patient is diagnosed as having a terminal condition. This terminal condition is clearly written in the patient's medical records (progress notes) and/or narrative summary and clearly written order on DD Form 602/AF Form 3899 and AF Form 3838.
16.1.2. The attending physician must provide the following documentation before the flight (IAW AFI 41-301): Completed AF Form 3838, DNR Certification for Aeromedical Evacuation, attached to DD Form 602 according to Air Force Joint Manual (AFJMAN) 41-306. The DD Form 602 should also contain a DNR order clearly spelled out as "Do Not Resuscitate," signed and dated by the attending physician not more than 72 hours before the originating flight.
16.1.3. The DNR order must not be more than 72 hours old prior to the originating flight and will cover the entire time in the AE system.
16.2. For medical-legal reasons, all documentation requirements must be met prior to flight. If any discrepancies, questions or concerns are noted, clarification should be obtained through GPMRC with the Patient Movement Clinical Coordinators.
16.3. The medical facility representative should be prepared to review all the documentation requirements with the Medical Crew Director (MCD) during the transfer report at the time of enplaning.
16.4. AECMs will provide general nursing care for DNR patients, unless otherwise specifically directed by the attending physician's written orders on the DD Form 602/AF Form 3899.
16.5. DNR is the exclusive determination of the patient (or the next of kin if the patient is unable to respond). The patient or next of kin may revoke the directive at any time, either orally or in writing. Competency will not be an issue when a directive is revoked.

17. SMOKING ON AE AIRCRAFT. Smoking on any aeromedical evacuation flight is prohibited. This is in effect for all aircraft designated for aeromedical evacuation. Smoking is prohibited anywhere on the plane to include rest rooms.

18. GPMRC LIAISON PROGRAM. The GPMRC conducts liaison visits to MTFs throughout CONUS and near offshore as needed.
18.1. Liaison visits are performed by a PMOO and a PMCC from GPMRC. A GPMRC regulator or VA liaison officer may accompany, if specifically requested by the facility to GPMRC. The purpose of the visit is to provide education and information to physicians, nurses, and administrative personnel of user facilities in the many aspects of Patient Movement.
18.2. Visits consist of a briefing by a GPMRC PMOO and PMCC (and GPMRC regulator and VA liaison officer when requested) on the administrative and medical facets of patient movement. The briefing and question/answer session usually takes 1 hour to complete.
18.3. The PMOO will conduct a staff assistance visit with AE personnel using the GPMRC staff assistance checklist. The AE Clerk will be provided with a copy of the completed checklist and numerous reference materials to develop or upgrade the facility's AE program. MTFs are scheduled for liaison visits by GPMRC. Prior to a visit, a facility will be contacted by letter and telephone by the project officer to establish a date and time for the visit. A follow-up letter will be sent confirming dates and times for the visit.
18.4. Information about the GPMRC liaison program may be obtained by contacting the Director of Administration at DSN 779-7144.

NOTE: Persons having questions not covered by this pamphlet or any aspect of patient movement are invited to call the PMOO at the GPMRC anytime at DSN 779-7155 or commercial (618) 779-7155/1-800-874-8966. It is open 24 hours every day.

GLOSSARY OF REFERENCES, ABBREVIATIONS, ACRONYMS, AND TERMS

Section A—References

Department of Defense (DOD) 4515.13R, Air Transportation Eligibility
DOD Instruction (DODI) 6000.11, replaced chapter 5 of DOD 4515.13-R
Air Force Instruction (AFI) 13-207, Preventing and Resisting Aircraft Piracy (Hijacking)
Air Force Policy Directive (AFPD) 41-3, Worldwide Aeromedical Evacuation
AFI 41-301, Worldwide Aeromedical Evacuation System
Air Force Joint Manual 41-306, Physician's Roles and Responsibilities in Aeromedical Evacuation

Section B—Abbreviations and Acronyms

ACLS	Advance Cardiac Life Support
AE	Aeromedical Evacuation
AECM	Aeromedical Evacuation Crew Member
AES	Aeromedical Evacuation Squadron
AFOC	Air Force Operations Center
APES	Automated Patient Evacuation System
ASTS	Aeromedical Staging Squadron
DMRIS	Defense Medical Regulating Information System
Domestic AE System	Continental US and near offshore area
EDS	Electronic Data System
FAA	Federal Aviation Administration
GPMRC	Global Patient Movement Requirements Center
IMP	Invited Medical Personnel
MEA	Medical Attendant
MCD	Medical Crew Director
MTF	Medical Treatment Facility
NMA	Non-medical Attendant
PMCC	Patient Movement Clinical Coordinator (Flight Nurse on duty in GPMRC)
PMOO	Patient Movement Operations Officer (MSC/Medical Service Officer on duty in GPMRC)
RON	Remain Over Night
TPMRC	Theater Patient Movement Requirements Center
TRAC2ES	TRANSCOM Regulating and Command and Control Evacuation System
VA	Veterans Administration

Section C—Terms

Not used.

PATIENT REPORTING DATA COLLECTION SHEET

Reports Control Symbol RCS:

ATTENTION REFERRING PHYSICIAN: AEROVAC patients travel at an aircraft cabin altitude of 8,000 to 10,000 feet. Please consider the effects of stresses of flight on this patient including barometric pressure changes, decreased partial pressure of oxygen, decreased humidity, temperature variations, noise, vibration, and fatigue. Complete shaded areas and Patient Preparation Checklist on reverse.

1. NAME *(Last, First, Middle Initial)*	2. SSN	3. PRECEDENCE	4. STATUS	5. GRADE	6. AGE	7. SEX Male / Female	8. WEIGHT

9. RDY DATE	10. DDS	11. PLACE OF RESIDENCE	12. SPEC CAT	13. MODE	14. REAS REG	15. DATE LAST VISIT

16. CLASS	17. ACCEPT PHYSICIAN NAME AND PHONE NO.	18. AUTH NO.	19. APPT/SURG DATE	20. APPROVAL AUTHORITY

21. CANC/INC	22. VALID	23. MTF ORIGINATION CODE	23. MTF ORIGINATION NAME	24. ICAO ORIGIN	25. MTF DESTINATION CODE	25. MTF DESTINATION NAME	26. ICAO DEST

27. MED SPEC 1	28. DIAGNOSIS 1 CODE	DEFINITION

29. MED SPEC 2	30. DIAGNOSIS 2 CODE	DEFINITION

31. MED SPEC 3	32. DIAGNOSIS 3 CODE	DEFINITION

32A. PROCEDURE	CODE	TYPE	33. SPECIAL DIETS *(If Yes, specify)* YES / NO	34. IV *(If Yes, specify)* YES / NO

35. O 2/LPM *(If yes, specify)* NO / YES	36. SUCT NO / YES	37. NG TUBE NO / YES	38. RESP NO / YES	39. FOLEY NO / YES	40. STRYKER NO / YES	41. INCUB NO / YES	42. TRACT NO / YES

43. IV PUMP NO / YES	44. CAST/LOC *(If yes, specify)* NO / YES	45. TRACH NO / YES	46. MONITOR NO / YES	47. SUPPLEMENTAL INFO

48. MAX ENRTE STOPS NO / YES	49. MAX NUMBER RONS NO / YES	50. ALT REST/MAX HT NO / YES	51. MISSION NUMBERS	52. RON LOCATIONS

53. INPATIENT NO / YES	54. SPECIAL PROGRAMS VA / DRUG / ALCOHOL / WEIGHT / NONE	55. VA CODE	56. ADMIN/OVERSEAS	57. VAL BY/REAS HIGH PREC

58. VITAL SIGNS TEMP	PULSE	RESPIRATION	BLOOD PRESSURE	59. HGB	60. HCT	61. ABG / DATE TAKEN	62. WBC	63. SI/VSI

64. MEDICATIONS NO / YES *(List all, even if self medicating)*

65. HISTORY *(Concise summary of most current diagnoses, treatment and prognoses. Also complete Patient Preparation Checklist on reverse. If additional space is needed, continue on reverse)*

66. ATTEND PHYSICIAN *(Print Name)*	67. PHONE NO.	68. WARD/PHONE NO.	69. REPORTED BY	70. PHONE NO.	71. PATIENT BAGGAGE TYPE	TAG NO.	WEIGHT

ATTENDANT 1

74. NAME *(Last, First, Middle Initial)*	75. STATUS	76. GRADE	77. AGE	78. SEX	79. RELATIONSHIP TO PATIENT	BAGGAGE 80. TYPE	81. TAG NO.	82. WT

ATTENDANT 2

83. NAME *(Last, First, Middle Initial)*	84. STATUS	85. GRADE	86. AGE	87. SEX	88. RELATIONSHIP TO PATIENT	BAGGAGE 89. TYPE	90. TAG NO.	91. WT

TRANSPORTATION

92. ORIG PHONE NO.	93. DEST PHONE NO.	94. ETA ORIG MTF DATE	TIME	95. ETA DEST MTF DATE	TIME	96. AIRCRAFT ITINERARY

97. OTHER COMMENTS

SAMPLE

AF FORM 3839, 19950301 *(EF-V2)*

PATIENT PREPARATION CHECKLIST

GENERAL CONSIDERATIONS:
Special diet is listed in Block 33 Per AFJI 41-303.
If inpatient or hypertensive/cardiac outpatient, vital signs must be given in Block 58.
If blood disorder, immunocompromised, or post-op, Hgb/Hct and WBC must be given in Blocks 59-60, 62.
All current medications and dosages written in Block 64.
Brief synopsis of current illness/injury and why patient being airlifted written in Block 65.
Significant additional or chronic medical problems addressed in Block 65.
If minor or incompetent non-active duty, complete the DD Form 2239, Consent for Medical Care and Transportation in the Aeromedical Evacuation System.

HISTORY OF CARDIAC OR PULMONARY PROBLEMS:
Last episode of chest pain and/or shortness of breath? _____
Can patient walk 50-100 feet and up a flight of stairs? ☐ NO ☐ YES If NO, must be litter.
If chest tube, Heimlich valve must be in place.
If chest tube removed, no flying for 24 hours and do expiratory PA CXR within 24 hours of flight.
Send CXR report with patient.
If TB and on antibiotics less than 2 weeks, mask is required.
Oxygen required or available? ☐ NO ☐ YES How much? _____

SAMPLE

POST-SURGICAL PROCEDURE:
Date of surgery _____
Condition of surgical site _____

HISTORY OF DIABETES:
Does patient need finger sticks? ☐ NO ☐ YES How often? _____
Most recent blood sugar? _____
Sliding Scale insulin? ☐ NO ☐ YES Order _____

HISTORY OF SEIZURE OR CNS DISORDER-
Date of last seizure _____
What do seizures look like? _____
What is current mental status? _____

HISTORY OF PSYCHIATRIC DISORDER:
If at all suicidal/homicidal, MUST BE 1A or 1B.
If IA or 1B, MUST BE in pajamas, be on litter, restraints available, be premedicated + have sedative ordered prn.

OBSTETRIC DIAGNOSIS.
Number weeks gestation? _____ G _____ P _____ AB _____ FHT _____
Any symptoms of labor - i.e, contractions, bleeding, ruptured membranes, dilatation, effacement?

ALCOHOL ABUSE AND OR DRUG ABUSE
Date of last use? _____

EAR, NOSE AND THROAT PROBLEM:
Able to clear ears/valsalva? ☐ NO ☐ YES
Cleared to fly by either ENT physician or Flight Surgeon? ☐ NO ☐ YES Name _____

PATIENT ON TOTAL PARENTERAL NUTRITION:
TPN: Change to D10 at _____ cc/hr. for max _____ days

65. HISTORY *(Continued)*

STAMP AND SIGNATURE OF ATTENDING PHYSICIAN | DATE *(YYYYMMDD)*

PATIENT REPORTING
INTRODUCTION

The information in this guide must be provided at the time of reporting for patients with diagnoses listed. Vital signs will be needed for inpatients only.

Ask about diets. Do not assume patients are on a regular diet! (Refer to DMRIS Manual).

Patients reporting from a civilian hospital through military channels may have very inadequate information provided. Please obtain as much information in the guide as possible.

On all patients, ask if there is any other diagnosis besides the one given. Frequently, the diagnosis which will be of most concern in flight is not reported; therefore, list all diagnoses.

Post operative patients. Patients may not be moved until all trapped gas resulting from surgery has resolved. This is normally after the 5th post operative day for patients post abdominal surgery.

Orthopedic and spinal cord injuries. Patients will not be moved with swinging weight traction.

In the event of a cardiac or respiratory arrest inflight, resuscitation efforts will be undertaken by the medical crew according to standing orders published for use in aeromedical evacuation. Do Not Resuscitate (DNR) orders will be followed when properly documented by the attending physician and terminally ill patient.

A plaster cast should be at least 48 hours old and dry. If there is any potential for circulatory compromise at altitude, casts should be bivalved for flight.

PATIENT REPORTING

BLOOD DISEASES (leukemia, anemia, neutropenia):
- Most recent hemoglobin (HGB), hematocrit (HCT), and white blood cell count (WBC); date of tests - Vital signs
- Is the patient bleeding now? If so, from what source?
- Does the patient require a transfusion? If so, when was last transfusion and post-transfusion HGB/HCT?
- Is special medication required?
- Is the patient on oxygen? If so, how much/what route? Provide most current O2 Sats.
- If the patient has a WBC less than 4.0, is the patient neutropenic? If yes, what precautions are taken?
- Does the patient require isolation? If so, what type?
- Why is the patient being airlifted?
- Is patient HIV positive? If so, what stage (refer to Attachment 7)? All Navy personnel must have a BUMED ltr, Ser #, and date in block 47. Date must be within the last 6 months.

CANCER
- Date of diagnosis? Site of cancer? Any metastasis? Pleural effusion?
- Has the patient had chemotherapy or radiation therapy? When? Lab results must be provided.
- Has the patient had surgery? When?
- Most recent hemoglobin, hematocrit, and white blood cell count and date of tests. (This is required for all inpatients and outpatients who have had chemotherapy or radiation treatments within the past 2 months.)
- Is the patient terminal?
- Is the patient DNR, Do Not Resuscitate? If so, an AF Form 3838/DNR form must be completed and faxed to GPMRC.
- Vital signs
- Why is the patient being airlifted?

CARDIAC DIAGNOSIS:
- Has the patient had a myocardial infarction (MI)? If so, the date, how was it ruled in, were there any complications?
- Does the patient have any chest pain? When was the last chest pain? Does it occur with activity or do they also have pain at rest? What relieves the chest pain?
- What activity is the patient permitted? (If the patient is unable to climb stairs or walk more than 50 feet, they must travel on a litter.)
- Does the patient have any pulmonary diseases or shortness of breath? How is it relieved? When was the last shortness of breath and how was it relieved? Is oxygen required? If so, how much/what route? If oxygen is required, what is the patient's O2 Saturation and the date?
- What medication is the patient taking?
- Vital signs
- Has the patient had a catheterization this admission? If so, what is the planned treatment?
- Did the patient have cardiac surgery this admission? If so, what is the patient's hemoglobin and hematocrit? Did the patient have chest tube post-operatively, when was it removed, date of latest chest x-ray and results?
- What type of IV drips are infusing, if any? Name each along with infusion rate.
- Is the patient on a cardiac monitor? What is the patient's rhythm? All patients on a cardiac monitor *must* have an ACLS certified nurse or physician as an attendant.
- Does the patient have a Pacemaker or any other type of cardiac implant? If so, the type/make/model/serial number/settings must be included in the record.
- Does the patient have an AICD (Automatic Implantable Cardio Defibrillator)? If so, make, model, serial number, and date last fired.
- Why is the patient being airlifted?

PULMONARY DISEASES:
- General questions for all pulmonary patients:
- Is the patient in respiratory distress now?
- Is oxygen needed? How much? How is it administered (i.e., mask, nasal cannula)? If on oxygen, what is the latest O2 Saturation, at what percent O2/liter flow? If O2 Sats are done on room air, state so.
- Vital signs

- Medications
- Is a ventilator required? If so, a Respiratory Technician familiar with the Bear 33 Ventilator must accompany the patient. If on a ventilator, vent settings and latest arterial blood gas results must be provided.
- Any other equipment required?
- Any chest surgery? If so, procedure and date.
- Hemoglobin and hematocrit; date of test.
- Does the patient have a chest tube, how many and location? For all patients with chest tubes, a Heimlich valve must be placed between the chest tube and chest drainage unit (CDU).
- If the chest tube has been removed, report the date. All patients must have a chest X-ray 24 hours after the tube has been removed, the results must be in the record.
- Any stop restrictions/RON restrictions/altitude restrictions?
- Any other medical problems? Any pleural effusion/what percent?
- Does the patient have a tracheostomy? If yes, what type and size?
- Asthma patient? Date of last attack and how relieved? List all medications and inhalers.
- Tuberculosis Patients:
- Is the disease active? Active but not contagious? Suspected but not confirmed?
- Is there a recent chest X-ray or skin test? What were the results?
- On tuberculosis prophylactic medications? How long has the patient been on these medications?
- Is isolation required? (All active, infectious, or suspected TB patients must wear a mask and are isolated. Arrested or active but noninfectious TB patients require no isolation and may be ambulatory.)
- Why is the patient being airlifted?

CEREBRAL VASCULAR ACCIDENT (CVA) OR STROKE:
- Date of the CVA/Stroke
- Is the patient conscious? If conscious, is there any confusion?
- Does the patient have partial or complete paralysis (paresis, hemiplegia, quadriplegia, paraplegia)?
- Does the patient have loss of function, loss of voluntary muscle movement, loss of sensation, weakness, headache, speech difficulty?
- What are the current vital signs?
- What is the cardiac status?
- Is the patient NPO or on tube feedings, special diet, need to be fed?
- Is the patient receiving TPN?
- Is any special equipment needed?
- Continent bladder/bowel? Does the patient have a foley catheter?
- Is there any respiratory distress?
- Does the patient have a tracheostomy? If yes, what type and size?
- Does patient have seizures? If so, date of last seizure?
- Medications
- Why is the patient being airlifted?

NEUROSURGICAL DIAGNOSIS OR SPINAL CORD INJURY:
- Date of injury or surgery and brief history of illness or accident

- What is the level of consciousness?
- Vital signs
- Is there any paralysis or loss of sensation?
- Is there any respiratory problem?
- Does the patient require any special equipment?
- Does the patient have traction? A special collar or cast?
- Is the patient NPO or on tube feedings?
- Does the patient have a foley catheter?
- Does the patient have seizures? Type and date of last seizure
- Does the patient have any other injuries or medical problems?
- Medications or treatments
- Hemoglobin, hematocrit, white blood cell count? Date of tests?
- Why is the patient being airlifted?
- Any evidence of trapped air? How confirmed? Need altitude restriction?

SEIZURES:
- Date of last seizure
- Length (duration) of seizure
- Type of seizure
- List any routine/PRN medications, dosages, route, and frequency.
- Why is the patient being airlifted?
- Indicate O2/suction available and Seizure Precautions on record

OBSTETRICS:
- Provide obstetrics history, G = how many times pregnant, P = how many live births
- Number of weeks pregnant
- Estimated time of confinement (EDC); i.e., baby's due date
- Fetal heart tones (FHTs)
- Any symptoms of labor? Contractions, bleeding, membranes ruptured, dilatation, effacement
- Any IVs?
- Any special diet or fluid intake?
- Any complications?
- Any other medical problems?
- Why is the patient being airlifted?

RENAL FAILURE/RENAL DIALYSIS PATIENTS/RENAL TRANSPLANTS:
- Laboratory Work: hemoglobin, hematocrit, and white blood cell count, date of tests
- Cardiac status
- Any special diet? If so, please give specifics on grams of protein and sodium, milligrams of potassium and phosphorus and any fluid restriction.
- Is patient on dialysis? Hemodialysis or peritoneal dialysis? How often is dialysis done? (Specify days of week, date of last treatment and plans for next treatment.) How is dialysis accessed?
- Current vital signs
- Any edema, swelling?
- Any other medical problems? Pericardial or pleural effusion?

- Why is the patient being airlifted?

NEONATAL/INFANTS:
- All diagnoses including all known or suspected congenital defects
- Gestation and date/type of delivery
- Was resuscitation required? Any complications with the birth?
- Is cyanosis present and are apnea or bradycardia episodes occurring? If so, what stimulation must be used to initiate breathing?
- What are the vital signs and what is the character of respirations? (Presence of nasal flaring, retractions, grunting, stridor, etc.)
- Give O2 Saturations if available. Report whether taken on O2/what percent or room air.
- How is the child getting nutrition?
- What special medical equipment or treatments will be required in flight?
- Names of any medical attendants
- Why is the patient being airlifted?

EAR, NOSE AND THROAT (Sinus and oral cavity):
- Is the patient able to clear ears? Valsalva?
- Has the patient been cleared by a Flight Surgeon or ENT physician for flight? Document in DMRIS name of Flight Surgeon/ENT physician clearing patient.
- Any altitude restriction required? Any evidence of trapped air?
- For DENTAL/ORAL SURGERY PATIENTS:
- Does the patient have wired jaws? If so, does the patient have wire cutters/scissors or quick release device and know how to use them if needed?
- Require suctioning?
- Require special diet?
- Any respiratory problems?
- Why is the patient being airlifted?

ALCOHOL/DRUG/WEIGHT PROGRAMS:
- Why is the patient going for treatment?
- Are there any psychological problems?
- What was the date of last drink/drug use?
- Is or has the patient experienced any withdrawal symptoms?
- What is the patient's bed date?

NOTE: Drug/alcohol abuse patients must have undergone a minimum of 72 hours detoxification prior to flight. Refer to Attachment 7 for additional guidance.

PSYCHIATRIC DISORDERS:
- List all diagnoses
- Is the patient Suicidal or Homicidal? Any attempts? If so, how and when; and any physical residual from attempt?
- Is the patient an elopement risk?
- Is the patient a management problem?
- List all medications the patient is receiving

- All 1A patients must be in pajamas, restraints, sedated, and on a litter, with a medical attendant trained to work with the restraints
- All 1B patients must have restraints, a litter, and IM/IV sedation available and travel with a medical attendant trained to work with the restraints
- 1C/5C cannot be Suicidal/Homicidal. If the patient is an elopement risk or management problem, then an attendant is required.

CIVILIAN AND VETERANS ADMINISTRATION (VA) MEDICAL TREATMENT FACILITY (MTF) REPORTING

The Global Patient Movement Requirements Center (GPMRC) is located at Scott AFB, Illinois. As part of the United States Transportation Command, GPMRC is responsible for coordinating the movement of all Department of Defense (DOD) beneficiaries from point of injury to definitive care including rehabilitation. Our goal is to move the patient at the *right time* via the *right mode* while providing the *right care*. Since you have requested movement of a DOD beneficiary, it is essential that the outstanding care you have initiated be continued throughout the transfer process. Adhering to the enclosed guideline will ensure that all COBRA regulations pertaining to interhospital transfer will be followed and a smooth transition for the patient will be provided.

The first step in the process is to complete the *required* transfer documents. Several documents may have been faxed to you for completion including: (1) AF Form 3899, Aeromedical Evacuation Patient Record, (2) AF Form 3890, Aeromedical Evacuation Inpatient Nursing Summary, (3) AF Form 3838, Do Not Resuscitate (DNR) Certification for Aeromedical Evacuation, and (4) DD Form 2239, Consent for Medical Care and Transportation in the Aeromedical Evacuation System. The first two forms listed are required for *all* patients traveling military transport. The last two forms are case specific and may not have been sent for your particular patient. Patient movement will not occur until *all* required forms are completed and faxed to GPMRC at (618) 229-0116/0118.

AF Form 3899 provides physician transfer orders and past medical history for flight. The attending physician is responsible for completing *Blocks 17, 19, 20 a-i, 22, 23, and 24.* All orders *must* be signed. A dictated Narrative Summary is required even though Block 22 is completed. AF Form 3890 provides continuity of care via a nursing care plan and should be completed by the primary nurse. Please pay close attention to the section titled: Current Medication Administration. Routine and *PRN* medications must be listed. A five-day supply of *all medications, including narcotics; intravenous fluids; and medical supplies such as Chux, colostomy appliances, tube feedings, toomey syringes, and catheter supplies MUST* accompany the patient to the flightline. On the day of transfer, please include a copy of the most recent Medication Administration Record with last dose of administered medications initialed. This will ensure continued accurate medication administration inflight. The hospital Medication Administration Record should coincide with the Current Medication Administration section of the AF Form 3890 and the physician's orders.

The Aeromedical Evacuation System does not permit "partial code" status on patient. If a patient is a DNR, AF Form 3838 *must* be completed. Please ensure this form is completed by the attending physician, and a DNR order spelled out as *Do Not Resuscitate* appears on the AF Form 3899, both forms signed and dated by the attending physician within 72 hours of flight. The form is invalid if the physician's signature is dated greater than *72 hours* before originating flight.

Thank you for your support in providing continuity of care for the patient and a smooth transition to a new facility. If you have any questions or if GPMRC can be of further assistance, please call 618-229-7150/8157 or 1-800-874-8966. A Patient Movement Clinical Coordinator (Flight Nurse) is available on a 24-hour basis to assist you.

AEROMEDICAL EVACUATION INPATIENT NURSING SUMMARY

1. NAME OF PATIENT *(Last, First, Middle Initial)*			2. SEX ☐ Male ☐ Female	3. AGE	4. STATUS	5. SERVICE	6. GRADE	7. SSN	8. DATE OF ADMISSION
9. ORIGINATING FACILITY	10. WARD	11. TELEPHONE NO.	12. DSN NO.	13. DESTINATION FACILITY				14. AMBULATORY ☐ YES ☐ NO	15. LITTER ☐ YES ☐ NO
16. NAME OF PHYSICIAN IN CHARGE AT TIME OF TRANSFER		17. TELEPHONE NO.	18. DSN NO.	19. NAME OF PERSON ACCOMPANYING PATIENT				20. RELATIONSHIP OF PERSON ACCOMPANYING PATIENT	

21. ADMITTING DIAGNOSIS

22. SECONDARY OR CONTRIBUTING DIAGNOSIS

23. ALLERGIES

24. MEDICAL ORDERS FOR CONTINUED CARE IN AE SYSTEM AND AT ENROUTE OVERNIGHT STOPS.
(Include medication orders, treatments, dressing changes, diet, activity, procedures, IV solutions and rate, etc.) TREAT AS TRANSFER ORDERS.

25. IS PATIENT COMPETENT TO MAKE HEALTH CARE DECISIONS? ☐ YES ☐ NO

IF NO, AND IS NOT ACTIVE DUTY,

IS DD FORM 2239, CONSENT FOR MEDICAL CARE AND TRANSPORTATION IN THE AEROMEDICAL EVALUATION COMPLETED? ☐ YES ☐ NO

DD FORM 2239 MUST BE ATTACHED TO THE DD FORM 602. DD FORM 2239 IS REQUIRED FOR UNACCOMPANIED MINORS AND INCOMPETENT NON ACTIVE DUTY PATIENTS.

26. DNR ☐ YES ☐ NO

If Yes, AF Form 3838, Do Not Resuscitate (DNR) Certification for Aeromedical Evacuation, must be completed and attached to the DD Form 602. If yes and unaccompanied, name and phone number of next of kin.

27. NURSING INFORMATION: *(ADL's Check Applicable Area for Each Condition)*

	SELF CARE	NEEDS ASSISTANCE	TOTAL CARE
AMBULATORY			
WHEEL CHAIR			
BATHING			
DRESSING			
EATING			
TOILETING			
MEDICATIONS			

28. PRIMARY LANGUAGE

☐ ENGLISH ☐ OTHER *(Specify)* _____

29.		30.	
FOLEY	☐	IV SITE LOCATION	_____
CONDOM	☐	DATE OF IN PLACEMENT	_____
DIAPERS	☐	DATE OF LAST TUBING CHANGE	_____
OSTOMY	☐		

SAMPLE

AF FORM 3890, 19950301 ***(EF-V2)***

31. REPORT BY NURSE CARING FOR PATIENT *(Include what you think the Flight Nurse needs to know about the care of this patient or what you would need/like to know if you received this patient on your floor.)*

32. EQUIPMENT, SUPPLIES, RECORDS SENT WITH PATIENT. AT LEAST THREE (3) DAYS *(US)* OR FIVE (5) DAYS *(OVERSEAS)* OF MEDICATIONS AND SUPPLIES MUST BE SENT WITH PATIENT. *(Check appropriate box)*

- CANE ☐
- CRUTCHES ☐
- WALKER ☐
- WHEELCHAIR ☐
- DENTURES ☐
- GLASSES ☐
- HEARING AID ☐
- DRESSINGS ☐
- IV SUPPLIES ☐
- RESPIRATORY THERAPY ☐
- MEDICATIONS ☐
- TUBE FEEDING SUPPLIES ☐
- SUCTIONING SUPPLIES ☐
- OSTOMY SUPPLIES ☐
- ORTHOPEDIC BRACE/SPLINT ☐

LOCATION _____

RECORDS SENT:

- XRAYS ☐
- INPATIENT RECORDS ☐
- NARRATIVE SUMMARY ☐
- OUTPATIENT RECORDS ☐

CAST NO ☐ YES ☐ LOCATION _____

(If injury is new, cast must be bivalved to compensate for potential swelling.)

IS CAST > 72 HOURS OLD YES ☐ NO ☐

IS CAST BIVALVED YES ☐ NO ☐

IF YOU HAVE ANY QUESTIONS OR NEED FORMS, PLEASE CONTACT THE AEROMEDICAL EVACUATION CONTROL CENTER.

33. CURRENT MEDICATION ADMINISTRATION *(Include PRNS)*

MEDICATION DOSAGE	TIMES GIVEN	TIME OF LAST DOSE

34. DATE OF TRANSFER FROM UNIT TO AEROVAC

35. NURSE'S SIGNATURE BLOCK

AF FORM 3890, 19950301 *(REVERSE) (EF-V2)*

DO NOT RESUSCITATE (DNR) CERTIFICATION FOR AEROMEDICAL EVACUATION

ATTENDING PHYSICIAN CERTIFICATION

I, _____, certify that I personally examined the patient
(Name of Attending Physician Clearly Printed)

identified as _____ and that he/she is suffering from a
(Name and SSN of Patient Clearly Printed)

terminal and incurable illness where death is imminent *(that is death could naturally occur at any time and, to a certainty, will occur within one year or less).* The patient and/or legal representative, having been so advised, has requested that resuscitation not be initiated in the event of a cardiopulmonary arrest during aeromedical evacuation processing to point of destination hospital.

A DNR order has been entered in the patient's medical record, dated _____ in accordance with the patient's/representative's informed consent.

NOTIFICATION OF NEXT OF KIN		PATIENT/NEXT-OF-KIN OR LEGAL GUARDIAN	
PRINTED NAME *(Last, First, Middle Initial)*	TELEPHONE NUMBER	SIGNATURE	TELEPHONE NUMBER

ATTENDING PHYSICIAN		
SIGNATURE	TELEPHONE NUMBER	DATE *(YYYYMMDD)*

AF FORM 3838, 19970801 *(EF-V2)*

SAMPLE

DO NOT RESUSCITATE (DNR) CERTIFICATION FOR AEROMEDICAL EVACUATION

ATTENDING PHYSICIAN CERTIFICATION

I, _____, certify that I personally examined the patient
(Name of Attending Physician Clearly Printed)

identified as _____ and that he/she is suffering from a
(Name and SSN of Patient Clearly Printed)

terminal and incurable illness where death is imminent *(that is death could naturally occur at any time and, to a certainty, will occur within one year or less).* The patient and/or legal representative, having been so advised, has requested that resuscitation not be initiated in the event of a cardiopulmonary arrest during aeromedical evacuation processing to point of destination hospital.

A DNR order has been entered in the patient's medical record, dated _____ in accordance with the patient's/representative's informed consent.

NOTIFICATION OF NEXT OF KIN		PATIENT/NEXT-OF-KIN OR LEGAL GUARDIAN	
PRINTED NAME *(Last, First, Middle Initial)*	TELEPHONE NUMBER	SIGNATURE	TELEPHONE NUMBER

ATTENDING PHYSICIAN		
SIGNATURE	TELEPHONE NUMBER	DATE *(YYYYMMDD)*

AF FORM 3838, 19970801 *(EF-V2)*

SPECIAL PROCEDURES FOR DEFENSE MEDICAL REGULATING INFORMATION SYSTEM (DMRIS) INPUT

1. Special programs - ALCOHOL, DRUG, WEIGHT:

- Indicate destination MTF in field 25, and indicate reporting bed dates in field 47.

GPMRC DOES NOT REGULATE SPECIAL PROGRAMS.

2. Medical Specialties - MMFA or MMFB:

- Indicate destination MTF in field 25, and accepting physician in field 17.

- Army and Air Force patients may be reported as inpatients (field 14 - CC) or outpatients (field 14 - OP).

- Navy patients *must* be reported as inpatients (field 14 - CC).

- Use appropriate Medical Specialty and Diagnosis Codes:

MMFB	- V7379	- HTLV	III	ANTIBODY	POS.	CLASS OF INFECTION UNSPECIFIED
MMFB	- V7371	- HTLV	III	ANTIBODY	POS.	CLASS 1 OF INFECTION
MMFB	- V7372	- HTLV	III	ANTIBODY	POS.	CLASS 2 OF INFECTION
*MMFA	- V7373	- HTLV	III	ANTIBODY	POS.	CLASS 3 OF INFECTION
*MMFA	- V7374	- HTLV	III	ANTIBODY	POS.	CLASS 4 OF INFECTION
*MMFA	- V7375	- HTLV	III	ANTIBODY	POS.	CLASS 5 OF INFECTION
*MMFA	- V7376	- HTLV	III	ANTIBODY	POS.	CLASS 6 OF INFECTION

MMFB	- V7260	-	SEROLOGIC TEST ONLY-HTLV III ANTIBODY NEG (ELISA NEG)
MMFB	- V7261	-	SEROLOGIC TEST ONLY-HTLV III ANTIBODY UNCONFIRMED
MMFB	- V7262	-	SEROLOGIC TEST ONLY-HTLV III ANTIBODY POS (WESTERN BLOT)
MMFB	- V7269	-	OTHER LABORATORY EXAMINATIONS

*MMFA - 27916 – Acquired Immunodeficiency Syndrome Related Complex (ARC)

*All HIV patients coded "MMFA *must* have current HGB, HCT, and WBC" for input into DMRIS

3. CIVILIAN MTF to CIVILIAN MTF:

- Field 23 (ORIG MTF) - enter C0010 plus the name, city, state and zip code of originating facility.

- Field 25 (DEST MTF) - enter your MTF code.

- Field 47 (SUPP INFO) - indicate name, city, state and zip code of destination facility (GPMRC will update field 25 with this INFO).

- Field 69 (REPORTED BY) - enter your MTF Code plus your last name.

- Field 92 (TRANS ORIG PHONE#) - enter phone number for ground transportation from the ORIG. MTF to the servicing airfield.

- Field 93 (TRANS DEST PHONE#) - enter phone number for ground transportation from the servicing airfield to the DEST. MTF.

- Field 97 (OTHER COMMENTS) - indicate specific POCs for transportation, if available, and alternate transportation phone numbers.

- All other information will be reported following normal procedures.

4. FAMILY PORTION OF ALCOHOL/DRUG/WEIGHT PROGRAM:

- Participants in the Family Portion of an Alcohol/Drug/Weight Program are not "non-medical attendants". Report these individuals as "outpatients."

PROGRAM	#14	#27	#28	#16-GOING	#16-RETURNING	#54
Alcohol	OP	MPSA	V6141	5B	**5B	ALCOHOL
Drug	OP	*MMI	V6149	5B	5F	NONE
Weight	OP	MMI	V653	5A	5F	NONE

* Request in Field 47 for GPMRC to change Med Spec to MPSD
** Request in Field 47 for GPMRC to change Class to 5F

5. Outpatient Psychiatric Patients:

- For outpatient psychiatric patients going to or returning from treatment:
  Reas Reg: *OP* Class: *5C* Med Spec: *MPPG*

- If patient is returning from treatment, request in Field 47 for GPMRC to change Class to 5F

6. US Public Health Service (PHS) or National Oceanic and Atmospheric Administration (NOAA) Patients:

- When reporting a PHS or NOAA beneficiary for movement you must first obtain (PHS) authorization.

- Contact a Patient Care Coordinator (PCC) at the Health Services Support Branch, Public Health Service, Rockville MD Phone #: 800-368-2777 or 301-443-1943, Mon thru Fri, 0800-1630 hrs (Eastern Time).

- Routine patients must receive authorization prior to movement.

- Non-routine patients can be moved without prior PHS approval; however, the transferring MTF must contact the Health Services Support Branch within 72 hours of patient transfer/movement.

7. Active Duty to VA Hospitals:

- Reason Regulated (field 14) is PR, Medical Specialty #1 (field 27) must be VAP, mark VA special program (field 54), appropriate VA Code (field 55), and Destination Transportation Phone # (field 93).

- Include VA Bed Designation Request reference #, when required, in field 47.

DRUGS ABOARD AE AIRCRAFT

Controlled Drugs

Demerol Inj Tubex 100 mg
Morphine Sulfate Inj Tubex 10 mg
Percocet Tabs 5 mg
Tylenol #3 Tabs
Valium Tabs 5 mg
Valium Inj 10 mg

Routine Drugs

Adenosine 6mg/2ml vial
Afrin Nasal Spray
Atropine 0.1mg/cc Bristojet
Benadryl 50 mg/ml Inj
Bretylium 500 mg/10ml amp
Bretylium 500 mg/250cc D5W
Calcium Chloride 1Gm vial
Calcium Gluconate 1Gm vial
Dextrose 50% Inj
Dilantin Inj 50 mg/cc Inj
Dopamine 40 mg/cc amp
Dramamine Tabs 50 mg
Epinephrine 1:10,000 Bristojet
Epinephrine 1:1,000 amp
Heparin lock flush, 100 units/cc
Inderal Inj 1 mg/cc
Isuprel 1:5000 5ml amp
Mylanta
Narcan (adult) 0.4 mg/cc
Neosynephrine 1/4% drops
Nitroglycerin SL 0.3 mg
Phenergan 25 mg/ml Inj
Potassium Chloride 2 mEq/cc Inj
Procainamide 100 mg/ml vial
Procardia Caps 10 mg
Sodium Bicarbonate 44.6 meq/50ml Bristojet
PEDIATRIC Sodium Bicarbonate 4.2% Bristojet
Sudafed Tabs 30mg
Tylenol drops 80 mg/0.8 ml
Tylenol Tabs
Xylocaine HCL 100 mg/5 ml
Xylocaine HCL 2 gm
Verapamil 5 mg/2 ml vial
Saline/Water for Inj

NOTE: Only a minimal selection of drugs is carried aboard aeromedical evacuation aircraft and in limited quantities. A 5-day supply of medications (except narcotics) is therefore required for all patients moving within the Domestic AE System and a 7-day supply if traveling to or from overseas. Provide narcotics only if patients require high or frequent doses or the medication is not listed above.

AEROMEDICAL EVACUATION DATA WORKSHEET

MISSION INFORMATION

DATE	MISSION NUMBER	TAIL NUMBER	ETA
ON LOAD - + + LITTER AMBULATORY ATTENDANT		OFF LOAD - + + LITTER AMBULATORY ATTENDANT	

NOTIFICATIONS

Notifications: The ward must be notified as soon as you receive notification from Scott AFB of the arrival of the aircraft SAMPLE

WARD

NAME	TIME
PHONE NUMBER	

AE TECH

NAME	TIME
PHONE NUMBER	

Notify Patient Administration immediately if a) the aircraft's ETA is earlier than 1200 hrs on a duty day, b) the aircraft is arriving on a weekend or c) anytime a patient has an Urgent or priority status

PATIENT INFORMATION

ON LOAD

NAME	DIAGNOSIS	IN/OUT PATIENT	CLASS	SPECIAL EQUIPMENT/ATTENDANT REQUIREMENTS

OFF LOAD

NAME	DIAGNOSIS	IN/OUT PATIENT	CLASS	SPECIAL EQUIPMENT/ATTENDANT REQUIREMENTS

REPORT TAKEN BY

NAME	SIGNATURE	DATE

After completion, this worksheet is subject to Privacy Act of 1974.